APPENDIX 1

JPIAF 10 Whole System Performance Indicator 2006
West Dunbartonshire

1. Overview

1.1 Our JPIAF 10 feedback, summarised in table 1, indicates that while service levels are high, there has been a slight decrease in the levels of intensive homecare as measured by the current indicator. This, we believe, does not fully capture the innovations that have taken place over the past year to further target homecare input and provide more frequent (although shorter) visits to our most vulnerable clients.

1.2 Emergency admissions have increased which is disappointing, and although there has been a slight decrease in multiple emergency admissions, these too remain higher than we would have hoped. Issues around emergency and multiple emergency admissions are discussed further in section 4 of this response.

1.3 Delayed discharges remain a persistent problem although we expect the April 2006 census figure to show a decrease of 9 from the April 2005 position of 42 to 33. Section 5 provides further analysis of our plans to meet our Local Improvement Targets for delayed discharge during the coming year.

		2003	% change 2003-2004	2004	% change 2004-2005	2005
Population aged over 65	Pop. > 65	14,607	0.7%	14,707	-0.9%	14,568
Emergency Admissions	Emg. Ad	3,702	-3.3%	3,579	5.1%	3,763
Multiple Admissions	Mult. Ad	709	-3.1%	687	-0.7%	682
Delayed Discharges - Total	DD Total	24	79.2%	43	-2.3%	42
Delayed Discharges over 6 weeks	DD > 6 weeks	12	125.0%	27	18.5%	32
Geriatric Longstay	Ger. longstay	77	18.2%	91	-2.2%	89
Supported in Care Homes	Support in CH	514	-2.2%	503	10.7%	557
More than 10 hours of homecare	HC >10 hrs	353	19.4%	421	-1.0%	417
Single Shared Assessments	SSA					

Table 1: Summary of JPIAF 10 feedback

2. Introduction

2.1 The commentary included within this report, presented on behalf of the West Dunbartonshire Partnership, relates to an analysis of the key performance data provided within the JPIAF 10 letter of 28th February 2006.

2.2 Over the past year our partnership has invested considerable time and staff capacity in developing our Local Improvement Targets and capacity planning work (older people) in a bid to produce robust and challenging targets linked

to a longer term strategic view of reconfigured services. This work will also direct change in our operational environments.

2.3 The work that has been undertaken during the past year has placed significant emphasis on developing options to tackle the underlying issues that lead to higher than average rates of emergency hospital admission; multiple admission and delayed discharge. We have also been working towards maximising the opportunities that we anticipate will arise from working with a single NHS system and the new Community Health Partnership.

3. Population

3.1 Whilst in most parts of Scotland the over 65 population is increasing (almost 1% between 2004 and 2005), West Dunbartonshire is experiencing a small decline in this group with a reduction of almost one percent over the same period. Approximately 15% (n = 14,568) of the area's population are over 65 years, with 4,987 of these (34%) being between 75 and 84 years, and 1,453 (10%) being 85 years or older.

3.2 The needs of the West Dunbartonshire senior population will be greater that elsewhere in Scotland on account of poverty, ill-health and living alone. In West Dunbartonshire the average life expectancy for both men and women is the third lowest in Scotland (and indeed the whole of the UK) after Glasgow City and Inverclyde. For males, life expectancy currently stands at 70.7 years against the Scottish average of 73.8 years, and 77.6 years against the Scottish average of 79.0 years.

4. Emergency Admissions/Multiple Admissions

4.1 Our JPIAF 10 analysis as presented in the 28 February letter indicates that the number of emergency hospital admissions for people aged 65 years and over has risen during the year 2004/05. In a bid to understand why this has occurred we are currently analysing emergency admissions by five year cohorts and by main reason for admission. This will help us to identify the key risk factors and conditions, and will inform future Local Improvement Targets and service redesign priorities within the capacity planning framework.

4.2 Initial work indicates that the most common reasons for emergency admission in West Dunbartonshire for those aged over 65 are chest and lung complaints, falls and heart conditions/disease. Our well-documented record of an industrial past, and our more recent history of high levels of social deprivation may well be manifesting itself now in terms of some of the

conditions that we are seeing in our ageing population. The work completed to date has been incorporated into our draft capacity plan which is currently out for local consultation (until 31st July 2006). The draft capacity plan also takes account of our commitment to future Local Improvement Targets and how these may need to develop to take account of an ageing and more frail local population. The next phase of the capacity planning work will develop a detailed financial plan that will enable use to identify the resources needed to develop health and social care systems that specifically target the key areas that lead to emergency hospital admission (for example, the management of heart and lung conditions).

4.3 We note that the analysis shows a small improvement in the number of older people subject to multiple emergency admissions. We believe that the numbers for this indicator are still too high, and our work on unplanned admissions will include investigation into reasons for admission, to ascertain the extent to which these multiple admissions are due to the same underlying reason(s). To retain partnership focus on the need to further reduce unplanned and multiple unplanned hospital admissions, we have included this dimension within our Local Improvement Targets. This will be closely monitored during the coming year and we hope to see further reductions in the future.

4.4 The partnership operates jointly resourced rapid response teams, and these are designed to avert admission where possible and facilitate early hospital discharge whenever appropriate. We have set new performance targets for rapid response services (see JPIAF 11, Local Improvement Targets) and are currently working to harmonise the two separate recording systems that were used by the different parts of local systems prior to the dissolution of NHS Argyll & Clyde.

4.5 Falls remain an important cause of emergency admissions, and the new Rehabilitation and Assessment Directorate within NHS Greater Glasgow & Clyde will be working to implement the falls prevention strategy. We are committed to this work and see it as an important element in our drive to achieve our Local Improvement Targets to reduce emergency and multiple emergency admissions.

5. Delayed Discharge Performance

5.1 We view delayed discharges as an effect of system blockages in the overall balance of care. By reducing the number of unplanned admissions, and by developing a robust capacity plan, we aspire to ensuring that every older person who requires health, housing or social care services receives the right provision at the right time. Our evaluation shows that we already have high service levels, particularly within our homecare service. This however needs to be matched with equally high levels of community nursing and AHP

provision. Our capacity planning work will help us to identify what additional inputs are needed.

5.2 Continually strengthening links with housing providers should enable us to develop new models of sheltered housing that offer a real alternative to care home placements. The draft capacity plan suggests minimum levels for the future, and we are hopeful that by increasing the range and scope of community-based services, we can move to a more responsive and flexible way of providing care, thereby ensuring that whenever an older person has to be admitted to hospital, he or she can be discharged to the right care package as soon as hospital discharge is appropriate.

6. NHS Longstay Beds and Care Home Places

6.1 Another key strand of our capacity planning work is to further disinvest from NHS longstay beds. The draft capacity plan proposes that we should build more community care capacity by releasing resources currently locked into buildings-based care. We recognise that for the vast majority of older people, longstay hospital is not an appropriate model of care.

6.2 We also believe that there may be scope in the future to disinvest form some of our care home places once the right community care infrastructure is in place and we have robust systems for community-based management of those conditions that lead to hospital admission.

6.3 Once a definitive capacity plan has been agreed, progress towards its objectives will be closely monitored. While too many beds remain open, they represent an inappropriate use of our local resources, and are always vulnerable to becoming “blocked” as older people await an appropriate care package, which in turn acts as a contributing factor to our relatively high levels of delayed discharges.

7. Homecare

7.1 We are committed to providing as much homecare as is appropriate, within our partnership resources, and our approach over the past year has been to optimise the effectiveness of the service by specifically targeting inputs across a broad spectrum of need. We remain convinced that homecare is a key service to the local balance of care, and plan to undertake more detailed analysis over the coming year to ascertain future work-streams for the service, to take account of locally agreed priority action areas, for example, health improvement, maximising independence, and promoting social inclusion.

8. Single Shared Assessment

8.1 We believe that Single Shared Assessment offers a vital tool in ensuring that each person's needs are assessed in an holistic way. Despite the lack of appropriate electronic information sharing systems, the principles of SSA are new well integrated into local practice and culture. Our Local Improvement Targets for 2006/07 include a commitment to implement specialist SSA across a range of community care client groups. Specialist SSA development work will inform the review of our Guide to Accessing Services (eligibility criteria).

9. Overall Context

9.1 Our Partnership has studied the JPIAF 10 feedback from both 2005 and 2006, and used the information therein to revise and update our local improvement targets, with a view to improved targeting against the key indicators within JPIAF 10. We agree that there is a need to reduce unplanned hospital admissions, and are committed to undertaking this task in a thorough and rigorous manner. We believe that our work to identify the main conditions that lead to unplanned admission is vital to this process, and it will be followed through with targeted action.

9.2 The Local Improvement Targets will help us to mark progress, and we believe that these targets have been set at challenging levels.

10. Development Programme

10.1 The Partnership will continue to address the issues identified in the commentary above, through joint development programmes, and in particular finalising and implementing capacity planning for older people (including older people with mental illness). It should, however, be emphasised that the following development priorities need to be seen within the context of a longer-term strategic direction. The programme will continue to be influenced by new demands, both internal and external to the partnership, and the continuous evaluation and review of strategic priorities. Local Improvement Targets are a component of this review process.

10.2 Priority areas:

- **Joint Future:** the further development of integrated services for older people in West Dunbartonshire. Building on previous developments including Clydebank Community Older People's Team, integrated hospital discharge teams and an authority wide approach to planning dementia and advocacy services. We have now established a West Dunbartonshire-wide Older People's Strategy Group, which will lead the implementation of redesign.

- **Delayed Discharge Action Planning:** continued development of our agreed action plan including an increased emphasis on process improvements through the development of integrated hospital discharge teams, implementation on the guidance on choice, audit and evaluation of our current service framework and further investment in services to prevent inappropriate admission. Given that we have not achieved the level of progress that we had hoped fore by April 2006, we are now developing a detailed performance management framework that will require a monthly report to the senior management teams for Joint Future and the West Dunbartonshire CHP.

- **Capacity Planning and Balance of Care:** finalisation and implementation of a revised capacity plan and commissioning strategy including an enhanced range of community/housing based models and a further reduction in NHS continuing care.

- **Rehabilitation:** the Rehabilitation and Assessment Directorate will be fully engaged with the Older People's Strategy Group, and will inform all relevant aspects of the capacity plan across primary, secondary and social care.

- **Homecare:** we continue to try to deliver as many high quality homecare packages as possible within the constraints of available resources. We aim to strengthen the health improvement role of the homecare service over the coming year.

10.3 The work programme has been further developed to include the following:

- **Carers** – we recognise the invaluable contribution unpaid carers make to helping people to stay at home safely and to ensuring that healthcare needs are recognised and addressed so that they don't escalate to the point where a hospital admission may be required. Many of our unpaid carers are themselves older people, and as such may be subject to an unplanned hospital admission if they are not properly supported in their caring role. We have therefore further developed our Local Improvement Targets to articulate our commitment to carers under specific and measurable indicators.

- **Falls Prevention** – a strategic approach to planning and developing falls prevention and management.

- **Older Peoples Health Improvement** – our capacity planning work will emphasise the importance of Health Improvement in enabling older people to maximise their physical and mental health, and therefore independence.

- **Support to Care Home Residents** – Work is in progress exploring the current NHS support provided to Care Homes, particularly in Nursing, Dietetics and Speech and Language Therapy.

- **Performance Assessment Framework** – the development and implementation of our strategic vision for older peoples services supported by a comprehensive evaluation process including the development of Local Improvement Targets to deliver on the following strategic objectives:
    - To promote good health and quality of life
    - Support older people living independently
    - Prevent unnecessary hospital admission, provide appropriate care in hospital, and help people home after hospital
    - provide good quality longer term care where it is needed
    - ensure the physical and mental health needs of older people are recognised and addressed

11. Summary

11.1 The West Dunbartonshire Joint Future Partnership is developed a robust and progressive capacity plan for older people against a backdrop of high levels of deprivation and need for services. A whole system approach, built around a high degree of service delivery and planning integration, has seen significant development and service improvement across a wide range of fronts. The shared commitment will be further embedded in partnership arrangements with the ongoing development of our Community Health Partnership as a single NHS system across the whole of West Dunbartonshire.

11.2 While our performance in respect of delayed discharge has failed to meet our own aspirations, it is important to note that this is regarded as a key priority for our Partnership. We will continue to work through the underlying issues that lead to people experiencing a delay in their hospital discharge. This detailed work will be located within our capacity planning over the coming year.

11.3 We believe that our Local Improvement Targets for 2006/07 are challenging, and that they will help us to deliver a better quality of service to vulnerable people in West Dunbartonshire who may need health, housing or social work support.